A JOURNAL FOR NURSES

FEBRUARY 1941

GULLIVER'S BONDS

As Gulliver was restrained by the Lilliputian bonds, so are many individuals deprived of real health by numerous tiny daily deficiencies in their diet. Day by day, the aggregate deficiencies may reach a total of definite inadequacy. Lack of these essential vitamins and minerals in the diet, if only to a small degree, may constitute a serious drawback to optimum health states.

More and more the profession is recommending COCOMALT for normal and therapeutic diets. The rich full flavor of this malted food dietonic, added to milk, is an incentive for both young and old to drink milk. COCOMALT contains calcium, phosphorus, iron . . . Vitamins A, B_1, D and G . . . quickly energizing . . . body building nutrients. Recent studies and references* confirm these facts.

Cocomalt is used by many physicians in diets for growing children and adults; for pregnancy and lactation, malnutrition, anorexia, pre- and post-operative patients, convalescence, febrile diseases, gastro-intestinal conditions.

COCOMALT
The Malted Food Dietonic for All Ages

R. B. DAVIS COMPANY, Hoboken, N. J.

* Arch. of Ped. 56: Nov., 1939; Med. Record — Aug. 21, 1940; Med. Record — 150:1:1939; Arch. of Ped. 57:448 (July), 1940; Med. Record — 149: Jan., 1939; Surgery — 6:1:1939.

IN *This* ISSUE

February 1941 Vol. 4, No. 5

A JOURNAL R.N. FOR NURSES

Circulation over 100,000 registered nurses monthly. Editorial and business offices at Rutherford, N.J. DOROTHY SUTHERLAND, Managing Editor. MONA HULL, R.N., Editorial Associate. Advertising representatives: CYRUS COOPER, Eastern Manager, and GLADYS HUSS, Eastern Associate, Graybar Building, New York City; J. M. KEENE, Western Manager, 870 Peoples Gas Building, Chicago.

Debits AND CREDITS

INDUSTRY

Dear Editor:

All other activities ceased until I read my December R.N., which, like every other issue, I found intensely interesting from cover to cover.

I was particularly interested in your article on industrial nursing for this is the field I am hoping to enter. Can you suggest literature I could read or any subjects I could study that would help prepare me for this work? Also, what are the qualifications required by companies employing industrial nurses?

Leota E. Ganger, R.N.
Los Angeles, Calif.

[*See Mrs. Hull's second article on industrial nursing on page 18 of this issue. For a list of recommended standards write The National Organization for Public Health Nursing, 1790 Broadway, New York City. Additional information may be obtained from The American Association of Industrial Physicians and Surgeons, Volney S. Cheney, M.D., secretary, Armour & Co., Union Stock Yards, Chicago, Ill., and the industrial division of the American College of Surgeons, 40 East Erie St., Chicago, Ill.*—THE EDITORS]

SECURITY

Dear Editor:

I delight in re-reading past issues of R.N. and recently I came across an article [D & C, May 1940] by Rose A. Nash of Woodbridge, N.J. She stated that we are organized poorly in relation to pensions and old-age insurance. Does Miss Nash realize that nurses are classed as "domestics" in Washington?

The health department of New York City does not cover us for compensation in case of accident while on duty—although hospital attendants are eligible for this protection. The eternal "why" is never answered.

Nursing's educational requirements are high—but the compensation is low. For example, in the Indian Service, Army and Navy Nurse Corps, the salaries are very low compared to other Government positions where educational requirements are minimized and no physical exertion is required.

R.N., Elmhurst, N.Y.

[*Federal salaries are not so low as this reader seems to think. The Indian Service offers* $1,620 *to* $2,600 *annually with deductions for maintenance and retirement. The Army and Navy offer* $840 *to* $1,560 *with maintenance and a thirty-day vacation each year. Majority of Government nurses have the eight-hour day.*—THE EDITORS]

UNIFORMS

Dear Editor:

I live in a small town and I wish someone would tell me what we are to do to keep most of the waitresses in town from wearing nurses' uniforms. Even a few of the beauty operators have started wearing long-sleeved uniforms—which I think is the last straw!

We nurses here are expecting them to surprise us and come out with a cap on, any minute now.

Why can't we do something to stop them from wearing our uniforms? Someone please lend an idea!

Kathryn Boner, R.N.
Lebanon, Mo.

Dear Editor:

It's true, practical nurses *have* gone to the extreme of not only wearing our caps and standard white uniforms but also of posing as graduate nurses. But I think it is partly the R.N.'s fault...

Recently I heard a graduate nurse comment, "Well, if I were in their place I'd do the same thing if I could get away with it." Does such an attitude elevate the standards of our profession?

If we are to make any headway against

EDICATED TO THE PHYSICIANS, NURSES AND HOSPITALS OF AMERICA

SAVED: 75,000 BABIES

IN THIS COUNTRY, over 75,000 babies will *live* this year—who would have *died* 20 years ago.

This has been accomplished chiefly by a war on germs.

Against this ever-present danger, hospitals take truly extraordinary measures.

For instance, in modern hospitals, no one is admitted to the nursery except specially assigned nurses. Not even doctors are allowed inside. Every article that touches the baby's skin is sterilized.

And in most hospitals the baby is given a complete anointing at least once a day with *antiseptic* oil to help protect the skin against germs.

Mother, when you return home from the hospital with a baby of your own—remember that the precautions observed in hospitals have saved countless baby lives. So continue those precautions at home.

* * *

In most hospitals, babies are anointed with Mennen Antiseptic Oil, every day, from top to toe—to help keep their skins healthier and safer from germs. Continue this *daily* oiling at home—*right thru the first year.* And use the oil at every diaper change, too, to help prevent diaper rash and excoriated buttocks.

Baby powder, like baby oil, should also be *antiseptic.* So, mother, when you choose a baby powder, choose Mennen Antiseptic Powder. Made by a new process — hammerized — it is "smooth as air." And, most important, it is *antiseptic.*

Pharmaceutical Division

THE MENNEN COMPANY

Newark, N. J. Toronto, Ont.

A new crusade sponsored by Mennen

The above is the first of a series of messages to give public recognition to the achievements of Physicians, Nurses and Hospitals in lowering infant mortality.

Appears in:

LIFE — LADIES' HOME JOURNAL
McCALL'S — GOOD HOUSEKEEPING
PARENTS' — BABY CARE MANUAL
BABY TALK — CONGRATULATIONS

M. BURNEICE LARSON, *Director*

CHECKING ALL RESOLUTIONS!

Did you—among your New Year's Resolutions—include one to make 1941 a year of greater achievement in your profession? Did you, during the month of January, take any definite steps toward keeping that promise to yourself?

If lack of time, or lack of information concerning the opportunities for graduate nurses today are proving a handicap—write us a letter about it. Give us a thumbnail autobiography—a thumbnail sketch of the position you would like to secure. We'll reply at once, and within a few weeks you may be reporting for duty in a position which will give you an opportunity to exercise your special talents in a higher degree than ever before.

Perhaps some of you will recognize in the following opening the ideal for which you have been seeking:

> The pediatric supervisor in a university group of hospitals is planning to be married and to make her home thousands of miles away. She has asked to be released from her faculty appointment by March first, or before, if possible. The pediatric department is comparatively small; it is comprised of private and clinic wards and two nurseries. The classroom instruction for which the supervisor will be responsible consists of a course on Child Development and one on the Nursing of Children. The salary is a hundred twenty-five a month with maintenance—a month's vacation is granted annually.

If you would like to apply for this appointment, write, wire, or telephone us. Or write for information concerning other unusual opportunities. You will surely find one which is just right for you.

***The* MEDICAL BUREAU**

M. BURNEICE LARSON, *Director*
Palmolive Building, Chicago

the practical nurse threat, we must tighten up our viewpoints first. Next, we need the cooperation of physicians. We know that some doctors continue to recommend practical nurses and encourage them to wear white uniforms. It seems to me, therefore, that we must enlist the support of ethical physicians and ask them to give our profession the respect we nurses have for medicine . . .

I believe the nurse's professional apparel should be respected because it is, after all, the chief symbol of our profession in the eyes of the public . . .

Elizabeth Krawzyk, R.N.
Dayton, Ohio

GLAMOR

Dear Editor:

After reading "Man Wanted" [December issue], I feel like shouting BRAVO! The author certainly spoke for thousands of us (or will you other R.N.'s admit it?).

So many nurses chain themselves to that old notion of "all work and no play." It isn't fair to ourselves or to the profession to permit ourselves to become dull and lifeless.

Give us a little more glamor and less Florence Nightingale, I say. Let's resolve to leave the profession behind us at the end of each day, to leave it where it belongs: in the hospital and at the patient's bedside! Come on gals, let's get out of our old rut!

R.N., Port Arthur, N.D.

Dear Editor:

I'd certainly like to know how the author of "Man Wanted" is progressing with her experiment. I followed her advice, it worked, and I'm having the time of my life!

R.N., St. Louis, Mo.

[*She got her man!*—THE EDITORS]

SUB-PROFESSIONAL?

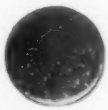
Dear Editor:

Why are registered nurses classed as sub-professionals in the Veterans' Administration? Certainly such a classification adds little credit to our profession. I believe a profession is an occupation that involves a liberal education and mental rather than manual labor. Surely nursing

GOODBYE DANDRUFF!

The Truth About Soap Shampoos

1. This photograph shows germs and dandruff scattered, but not removed, by ordinary soap shampoo.

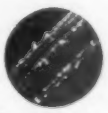


Soap Shampoo

2. All germs, dandruff and other foreign matter completely destroyed and removed by Fitch Shampoo.

Fitch Shampoo

3. Hair shampooed with ordinary soap, rinsed twice. Note dandruff and curd deposit left by soap to mar natural luster of hair.



Soap Shampoo

4. Fitch Shampoo and hair rinsed twice. Note Fitch Shampoo removes all dandruff, undissolved deposit, and brings out the natural luster of hair.

Fitch Shampoo

No nurse can afford to have dandruff. That's why nurses everywhere use Fitch's Dandruff Remover Shampoo for romantically lovely hair, actually antiseptically clean. Fitch Shampoo is sold under a money-back guarantee to remove dandruff instantly—a guarantee backed by one of the world's largest insurance firms. It penetrates and cleanses tiny hair openings on the scalp, helping the scalp to function normally. Equally efficient in hard or soft water, Fitch Shampoo is a scientific beauty treatment that reconditions as it cleanses. *Try it today!*

Nurses Prefer Fitch Shampoo for Patients

Fitch Shampoo is actually a germicide, so it is ideal for sickroom use. But there is another reason why Fitch Shampoo is a favorite for patients. It is applied to the hair and scalp dry. No water is needed until you rinse it out. Fitch Shampoo is easy and convenient to use.

The Best Bands

Listen to the FITCH BANDWAGON, presenting your favorite orchestras every Sunday, 7:30 p.m., E.S.T., over NBC Red Network.

Fitch's TRADE MARK

DANDRUFF REMOVER SHAMPOO

THE F. W. FITCH COMPANY, DES MOINES, IOWA . . . BAYONNE, N. J. . . . TORONTO, CAN.

can be placed in that category. What do other R.N.'s think about this?

Recently a banquet was held in honor of a chief administrator of veteran affairs. Tickets were purchased by members of the nursing profession and others, but the nursing group had the largest number in attendance. Sitting at the speakers' table were executives of various departments with their wives—but not a single member of the nursing staff. During the course of the evening various guests were introduced . . . but no effort was made to present any nurse, not even the chief nurse. It just seems as though nurses are only on the payroll like scrub women and window washers.

I don't know what other members of the profession think, but to me the incident was an insult. Let's hear some of your reactions.

R.N., Dayton, Ohio

FIRST LOVE

Dear Editor:

I have just read your December number and find it so democratic that I would like to contribute a bit of my experience to it.

In 1923 I went out of active nursing to enter the field of education, securing an A.B. degree and beginning to teach in a small college. Ten years later I was admitted to the Colgate-Rochester Divinity School where I obtained my B.D. degree. I was the first Baptist woman to be ordained in Monroe County, New York . . . Next I went to Columbia University and by 1935 had an M.A. But do you think with all these assets I could get a job? No!

After six months of travel, I decided to visit my own hospital. There I was cordially received and allowed to take a refresher course . . . Now I'm back on general duty after seventeen years' absence. I almost forget my aching feet for sheer joy that somewhere in the professional world there is a place for a woman sixty years old!

I am going strong and more than ever love the privilege of serving humanity through nursing . . .

B. M. Rothermel, R.N.
Troy, N.Y.

In the Prevalent Affections of the Winter Season

★ Sudden changes in temperature, exposure to sleet and snow, and the low humidity of modern dwellings, all contribute to the greater incidence of articular, muscular, and respiratory affections so prevalent during the winter months. While systemic medication is employed to advantage in these conditions, adjuvant local therapy usually provides the prompt symptomatic relief the patient seeks.

Baume Bengué, applied topically in rheumatic involvements, myositis, arthritis, influenza, and upper respiratory conditions, leads to quick relief of pain through its local rubefacient action and the percutaneous absorption of methyl salicylate.

Baume Bengué

ANALGÉSIQUE

THOS. LEEMING AND COMPANY, INC., 101 WEST 31ST STREET, NEW YORK, N. Y.

THERE IS TOO MUCH HUSH-HUSH ABOUT CONSTIPATION..

- As a nurse you undoubtedly know that constipation needs to be talked about. And when that's done, you can really do something to relieve common constipation.
- Medical research has devised an intelligent modern way. Many cases of constipation are due to the lack of sufficient bulk in the daily diet. Thus intestinal muscles which play an important part in elimination of waste may get too little exercise; soon they become flabby and constipated.
- SARÁKA *exercises the intestinal muscles.*
- SARÁKA was created to provide bulk and to help exercise intestinal muscles in a convenient, practical way. A few tiny granules . . . small and easy to take . . . expand to form the soft bulk so often needed to exercise the lazy and under-worked bowel.
- SARÁKA is different. The gentle bulk it forms is soft, not rough; smooth, not harsh; jelly-like, not oily. There is nothing exactly like SARÁKA. SARÁKA is *not* bulk alone. In addition to bulk it also contains a gentle vegetable aid to elimination. It supplies "softage," not roughage; softage with a plus,† for dual action.
- If you yourself suffer with common constipation, take SARÁKA faithfully for a few days and begin to re-educate your intestinal muscles. You will then realize why so many physicians have recommended SARÁKA* for their patients.

SARÁKA

FOR UNDER-WORKED INTESTINES

† Bassorin plus frangula.

* Trade Mark Reg. U. S. Pat. Off.

- **Dept. 300, Union Pharmaceutical Co., Inc.**
  Bloomfield, New Jersey

Please send me "The Inside Story of Constipation" and generous trial size sample of SARÁKA.

Name.....

Address.....

City.....State.....

We introduce SWAN

—a new, pure, floating soap as mild as fine, imported "100% olive oil" castiles

IT HAS LONG BEEN recognized by the medical world that fine, "100% olive oil" castile soaps are the standard of mildness and purity.

Medical literature abounds with references to the gentle, bland effect of these soaps on both infant skin and delicate adult skin.

In developing Swan, it was our aim to achieve castile standards of mildness and purity in an improved, but low-priced, floating soap.

Every test indicates that we have succeeded in our purpose.

Analytical laboratory breakdowns show that Swan is as pure as even the finest, imported "100% olive oil" castiles.

Clinical comparative tests, made by an independent laboratory of high repute, show that in nearly 80% of the cases Swan is as mild in its reaction on the skin as fine, imported "100% olive oil" castiles.

A grand summary reveals that 34% of the subjects showed no difference in their reactions; 43% reacted more favorably to Swan; and only 23% more favorably to castile.

There is, of course, every good reason for Swan's purity and mildness. It is made with painstaking care by one of America's most reputable soap manufacturers.

Every ingredient is checked for quality before it goes into Swan. All fats and oils are of high grade, carefully refined to remove impurities. Every batch of Swan is tested at each stage to insure uniformity in quality.

Swan has no free alkali or free fatty acids, no coloring matter, no strong perfumes. It will not go rancid.

In recommending Swan, you may be sure that here is a pure, mild soap that meets your most exacting requirements. And it's a soap with many practical advantages to boot.

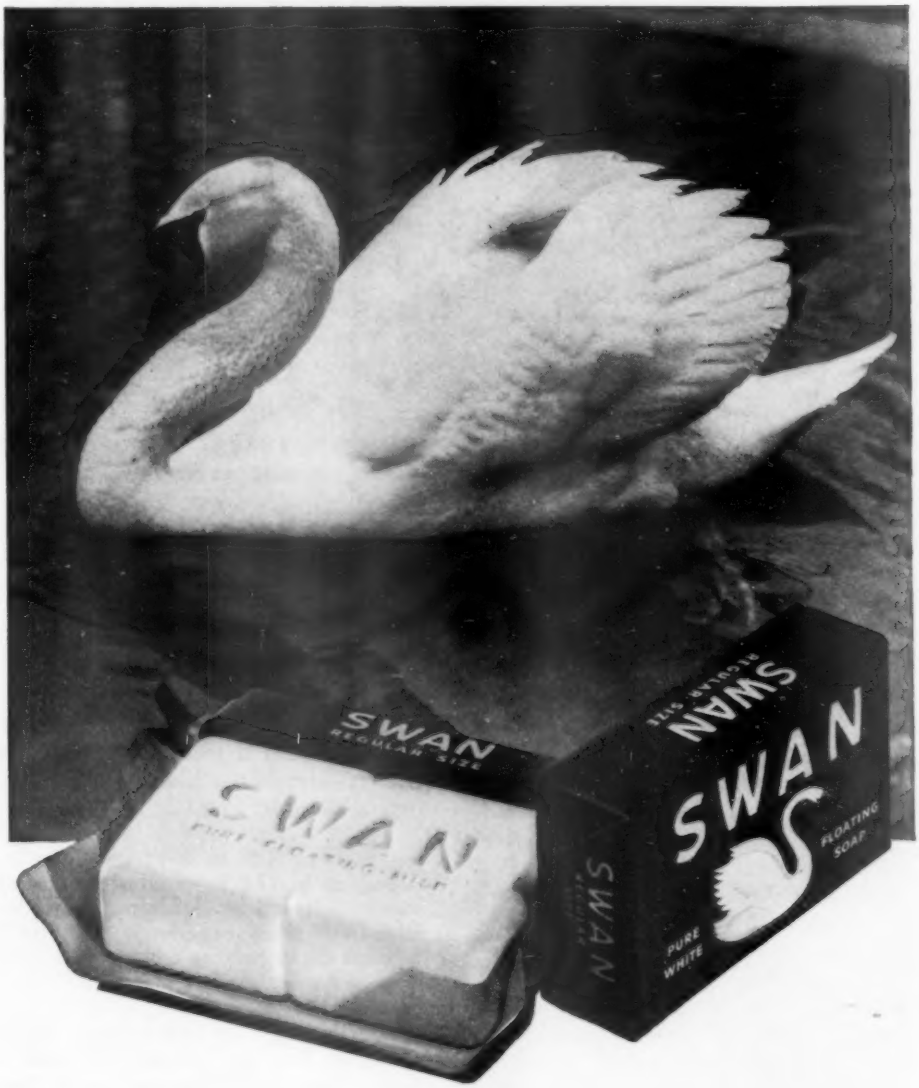
For Swan costs far less than fine, "100% olive oil" castiles. It costs no more than other leading floating soaps.

Yet your patients will like Swan better than old-type floating soaps because it suds two times faster. It's firmer. Longer-lasting. It's whiter, smoother, cleaner-smelling.

We'll gladly send you free samples to use in your work and at home. Simply write to Swan, Dept. C, Cambridge, Mass.

LEVER BROTHERS COMPANY
Cambridge, Mass.

to the nursing profession



NOTE: We are introducing Swan Soap area by area. Even though it may not be distributed in your city yet, we felt sure you would want to know about this unusual new soap in advance.

Photos courtesy Camp Fire Girls

SO YOU

BY ALICE BRYAN, R.N.

Do you love the country? Know how to get along with children? Some 10,000 nurses who do will take camp jobs next summer.

• Have you a hankering for a summer out-of-doors? Would you like to exchange your uniform and cap for a pair of shorts, and try nursing-in-the-woods? If you want a camp-nursing job, this is the time of year to start looking for it.

Between 7,000 and 10,000 nurses will go to camp this summer to hold clinic office-hours under the spreading chestnut tree. But these thousands don't make up their minds in June. They find their jobs between Christmas and Easter while the rest of the world is still tied up in winter routines. It's the early nurse who goes to camp. Veteran campers are already immersed in application blanks, interviews, and camping manuals. If you are planning a summer in the country, therefore, your cue is to start the quest now.

Camp R.N.'s are wanted by directors and personnel bureaus all over the country. Here's the kind of nurse they are looking for:

Fairly young (20 to 40); good nursing credentials and background of general experience. Must like children and, preferably, have some experience with them. Previous experience as a camper or camp nurse not essential but valuable.

Your camp experience may not be extensive, but you should be able to show evidence that you can handle first-aid situations. Private-duty nurses make good camp prospects, especially if they have worked with families and younger children. School nurses are eagerly sought, not only because they

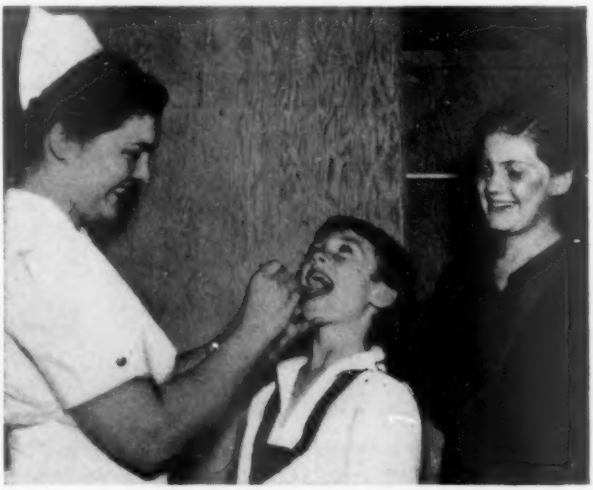
WANT TO GO TO CAMP!

can teach, but because their vacations fit nicely into camp schedules. R.N.'s with public-health experience have proved their all-around worth in handling big groups of children away from home.

Suppose you are moderately well equipped in these qualifications, but have had no camp nursing experience. Where do you start, and how do you find a really good camp position?

There are four good ways of locating your camp job, any one of which puts you in touch with first-class organizations and the better opportunities. The first, private contacts, is feasible only if (through schools or individuals in your community) you know of people who organize summer camps. Personal contact with the director, assistant director, doctor, or head counselor of a summer group is one of the quickest, most satisfactory ways of arranging your job—if you have the contacts! If you ever went to camp as an adolescent, you can go back there and ask for a job. You will certainly receive far more attention than any stranger applying, since you already know the camp's routine and objectives.

Lacking contacts, you can watch the employment columns of large newspapers. Under "Help Wanted—Female" look up commercial opportunities rather than nursing listings. The Sunday classified columns between now and Easter will be filled with camp ads entered chiefly by large private camps who select their entire personnel by this method. These notices will state that they need "all counselors," or "complete staff," or perhaps simply "counselors needed." Address your letter of application to the box number



Camp nurses make a game of routine health inspections. Children look forward to their weekly visits with "nursey."

and ask for an interview.

The third, and one of the best ways to get a position in a qualified camp is to go to the large national organizations who run hundreds of summer camps throughout the country. The Girl Scouts of America, the Camp Fire Girls, and religious organizations such as the Young Women's Christian Association, all need large numbers of nurses—and hire them through organization offices.

For years the Girl Scouts have accepted applications for positions in all their camps at national headquarters, 14 West 49 Street, New York City. Although the personnel office prophesies that some changes will be made in their employment system this year, a letter to headquarters will get you information on where to apply. You need not be a Girl Scout.

YWCA camps throughout the United States are most interested in locating qualified nurses for the summer. R.N.'s with school or public-health background, or some other teaching experience will be given first consideration. In the New York area, these nursing jobs pay $75 a month with maintenance. Application should be made to your local YWCA office rather than to national headquarters. (The first of March is a strategic time to apply since by that date YW officers know whether or not their old staffs are returning.)

Camp Fire Girls, 88 Lexington Avenue, New York City, will be glad to receive applications as soon as possible. This is the address of national headquarters. Interviews will be arranged with local camp officials.

Many excellent camp posts are secured each year through still another medium—nurses' registries. Both professional and commercial registries list many summer jobs, even as late as May or June. Your best bet would be to place your preferences for jobs with your favorite registry—early. When positions come in, the registrar will think of you. She will be inclined to place a nurse whose work she knows and whose personal traits she has had an opportunity to observe. Registries repeat the advice of all other camp-job sources: Don't wait to apply.

Your letter of application is the first

Next to ivy poisoning, sprained ankles are commonest complaint. Nurses have plenty of time to demonstrate bandaging!

contact which you make with your prospective camp employer. Make it impressive, specific, and detailed. Write it as you would any other job application letter, and make yourself sound interesting as well as efficient. The recipient isn't just looking for an R.N.; she's looking for a bright, attractive addition to her staff, a good influence on her campers, and a first-rate nurse to boot! In accurate, concise form, try to include a detailed summary of your nursing experience, your camp and teaching background, all your work with children and courses in child psychology. Camp directors will also be more interested if you have such added talents as a knowledge of music, handicraft, or a Red Cross lifesaving badge. Don't overlook any bets in selling yourself for a job you think you can fill.

Next comes your interview with a camp authority. Handle this as you have other job interviews, with some strategic attention to wardrobe and coiffeur. Although you're on the trail of an outdoor job, don't lean heavily on "outdoor-girl" accents. Wear your ordinary street clothes; feel comfortable.

There's one point to remember about your interview: *you* want to do some interviewing, too. Camp "Killkare" is as yet only a name to you, and unless it is a camp run by an organization with set standards, you yourself will have to decide from facts given you whether or not it is the kind of set-up you want. There are good, bad, and indifferent camps hiring staffs every year, and sad are the tales of R.N.'s who let themselves in, unwittingly, for a summer of poor sanitation, and incomplete supplies. Intelligent questions on your part, far from being resented, will prove your own knowledge of camping subjects.

You will want to know about the organization of the camp, under whose auspices it runs, what the general character of its personnel is. You'll want to know approximately how many campers there will be in proportion to counselors. (One counselor to ten campers is a good average, though better camps may have more supervision.) Ask, too, about camp sanitation and diet, and whether or not a dietitian is hired. You'll be most [*Continued on page* 46]

Under a doctor's supervision, periodic physical examinations keep tab on campers' health throughout the summer.

All in

the day's work!

International

BY MONA HULL, R.N.

• At the very least there are 3,500 industrial nurses in the United States. Experts calculate that there are probably almost 4,000 and that this number will rapidly swell during 1941. As motors and machines move off production lines, this pioneer group of R.N.'s in industry will bear watching. They are literally developing a *new* profession!

These four thousand, and the other hundreds that will join them as America prepares, are not office nurses; they're not clinic nurses; neither are they visiting nurses. They are as unlike as a factory and a hospital. From the industrial first-aid rooms of past decades they are developing an entirely new kind of nursing service with new professional standards—standards influenced by the unusual character of their work.

Industry OPENS UP PART 2

Predictions are that with defense expansion industry will need three times as many nurses as now in the field. Here's the second of a series of articles on what Mrs. Hull calls "a new profession."

A new group always changes things. Industry is no exception. Hence, the old rigid hospital etiquette is being modified, and even public-health techniques are being revised to fit factory health departments. Nursing itself is always basically the same; but its application to 49 million workers is a new problem—and an exciting job opportunity.

R.N.'s in industry say that one of the greatest assets of their field is the opportunity for daily contact with the "outside" world. In this field, as in no other, nursing meets large-scale business for the mutual benefit of both. But business isn't the only outside association. Away from the hospital and installed in a factory, the nurse earns fresh prestige in the eyes of other groups—Government agencies, medical planning boards, workers, welfare organizations. Her job is nursing, but she can nurse successfully in industry only when these groups back her and cooperate.

Picture the general staff nurse in a hospital ward. Her job is well outlined; she is responsible to her head nurse, ultimately to a supervisor whom she may seldom see. It's as simple as that. Then shift scenes to the R.N. in an industrial health department. Consider the variety of people with whom she works. Any or all of them may enter her work picture—the laborers who man the plant, the business staff, the clerical helpers, the packing and shipping departments, the heads of divisions, and the top-flight executives who pay her salary. To all these individuals she's the key to a preventive health program.

Some years ago Edward Filene, Boston department store tycoon, pointed out that the most notable advances in industrial health were made by the discovery that health was cheaper in the

long run than illness. As management continues to discover that more prevention means less time and money lost due to sickness, industrial-health programs grow by leaps and bounds. The increasing interest which employers are taking in health is shown by a recent factory-health study made by the National Association of Manufacturers. Although final tabulations of 2,000 questionnaires have not yet been completed, the NAM reports that a goodly proportion of plants queried have extended their nursing and health departments in the last twelve months, that another large percentage contemplates completely new hygiene and health programs.

Much of the interest of management in hygiene depends directly on the industrial nurse. In addition to doing a superior nursing job she must convince her employer that health supervision is vital—not merely a "show" department, or an after-thought. In no other branch of nursing is the individual nurse so responsible for selling good health to business management.

That the industrial nurse has brilliantly succeeded in getting along with business is witnessed by the praises which the factory R.N. rates from management at every employer meeting. J. M. Conway, president of the Hoberg Paper Mills of Green Bay, Wisconsin, said at a recent safety congress: "The industrial nurse increases the efficiency of workers, reduces cost of production . . . She is one of the greatest builders of goodwill in existence." Agreed Chester Johnson, personnel manager of the Quaker Oats Company, Cedar Rapids, Iowa: "The R.N. has a real function . . . in modern industrial relations. She establishes goodwill . . . the essence of industrial harmony." And, at the NAM convention in New York City in December, R.N. staff members interviewed employers from all over the country, found them registering unqualified approval of what nursing is doing for industry.

When employers were first made responsible for the injuries and illness of their workmen, industrial nursing was pushed another step in the direction of a new profession. Nowhere else in nursing does the R.N. as an individual officer deal with compensation systems and insurance companies.

Compensation laws may work in two different ways to affect the factory nurse:

1. Her company may work directly with compensation boards, paying for accidents and injuries as they occur. In this case the R.N. keeps records, holds many detailed conferences with local compensation officers.

2. Her plant may be insured to cover the cost of all such payments. If so, the insurance company enters the factory scene, tries to hold down accident costs to save money for itself.

Compensation insurance is carried on by all States except one—a fact which has definitely stimulated industrial nursing. Policyholders tend to employ nurses to help keep accident and injury rates down. One large insurance company, Employers Mutual Liability Insurance, employs a staff of twelve nurses who are engaged in an educational service to their policyholders in the field of health and safety. This service is extended to all areas where there are sufficient policyholders to justify the expense involved. One of its functions is to help plants to secure well-qualified public-health nurses and to follow up by offering advice and suggestions on local plant health and safety problems. Supervising the service is Joanna Johnson, first nurse to be placed in such a post and, it is believed, the only industrial nursing supervisor operating at the present time under an insurance company. Miss Johnson sees a great future in industrial nursing as its

growth parallels that of the growth of industry.

In the new field of factory hygiene —as in all other health services—nurses work with the advice and supervision of the medical profession. But in industry the relationship is quite unlike that of the hospital floor. Here, even more than in the hospital, the M.D. counts on the nurse for acute observation, accurate reporting, and quick decisions. A recent study of plant personnel by the National Industrial Conference Board illustrates this vividly:

In analyzing the personnel of 300 establishments, the board found that in 56.5 per cent of the plants a full-time nurse was employed, with an M.D. working part-time or on call. In only 10 per cent was there a full-time doctor in attendance. The moral is plain: In the great majority of plants the R.N. holds a post of unparalleled responsibility. She may decide whether or not the doctor is called. Her relationship with the physician must be particularly good, her knowledge of medical provinces infallible. (Incidentally, leaders in the medical profession agree that in the future, in most plants, better medical support will be given the nurse.)

Far from feeling that the industrial nurse is a competitor, doctors look on her as a valued co-worker. Witness the letter which Dr. Parran of the United States Public Health Service wrote to New England industrial nurses on their twenty-fifth anniversary:

"This corps of nurses, through their interest and ability, has already made a unique contribution . . . I urge you to prepare yourselves in even greater numbers to meet such additional demands as may be made upon you in effecting our National Defense Program."

Defense, naturally, brings Government into the picture where it formerly played a rela- [*Continued on page* 48]

PROBIE

"It looked so easy in class, yesterday."

The NURSING INVENTORY

• You are currently being asked to take part in a nationwide census of nursing resources—and to record for posterity all sorts of details on your background and experience.

According to the comments coming into R.N.'s office, some of you sent in your questionnaires quickly and enthusiastically. Others have been a little reluctant.

We wish every R.N. reader would consider it a patriotic obligation to participate in this census. Why? Because we think it is one of the most important defense projects under way at the present time. It ranks with the building of guns and ships, with the calling of conscripts into training.

The United States, in peace or war, is only as strong as the health of its civilian and military populations. Your Government cannot possibly sustain a high level of national health during an emergency period unless it knows how many doctors, nurses, and other workers are available to lend a hand.

Some nurses tell us they have not answered the questionnaire because they "don't want military service", don't want to be "regimented into a job" they may not like . . . Authorities insist that is not going to happen.

Actually, this survey is just a mammoth research project. When completed, it should give local and national officials an accurate

tally on the qualifications and fitness of nurses in all branches of the profession. Participation does not commit you to any action except mailing the form to State inventory headquarters.

Most of all, don't let your disinterest in military service deter you from providing the other information requested. To your local community—and to health officials in Washington—the facts about your preparation and nursing work are of the utmost importance.

As R.N. has been emphasizing since October 1939, we dare not neglect civilian health while we concentrate on building a healthy army. The vast majority of nurses, therefore, must stick to their present posts so that local communities will not face a nursing shortage. Probably the chief value of the survey will be its ability to show where nurses are, how they are serving, and whether the distribution of nursing service is adequate for the needs of specific health areas. Certainly this phase of the census is equally important as whatever it may indicate regarding the availability of nurses for military duty.

The USPHS advises you to file your questionnaire in the State in which you are currently employed, not necessarily in the State in which you originally registered. If you have not yet received a questionnaire, we suggest you communicate with your local district or State headquarters. And when you receive the form, by all means fill it out and return it at once.

QUICK FACTS ABOUT

CORONARY THROMBOSIS

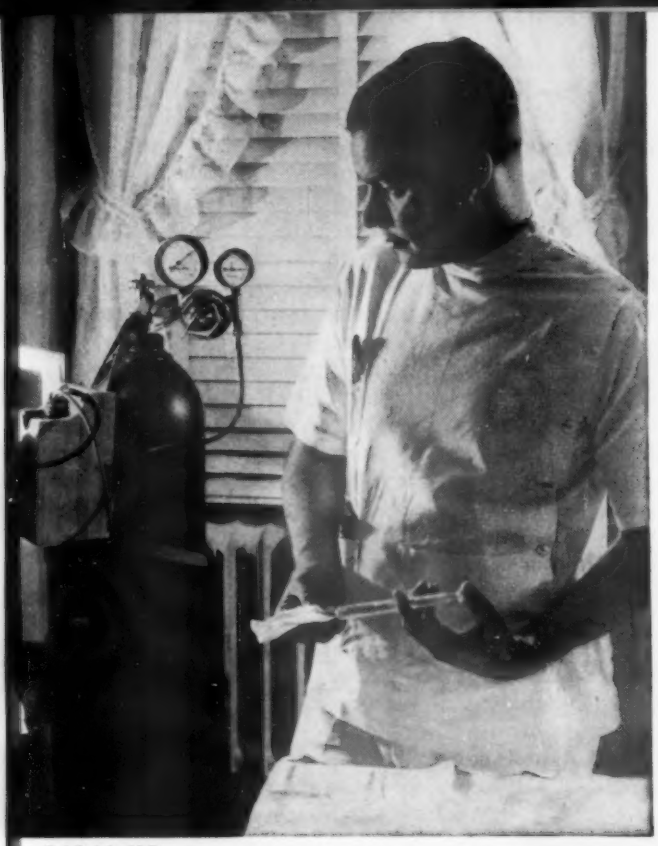
• Preventive medicine, together with the advance of science, has increased the life span from 37 years in George Washington's time to today's expectancy of 63 years. With this increase has appeared a greater number of degenerative diseases, not the least in importance being degenerative changes in the heart muscle. While there is divergence of opinion as to the cause, all authors agree that the greatest problem that presents itself is further delay of the onset as well as proper treatment.

Coronary thrombosis, the formation of a blood clot or thrombus in the coronary arteries, is one of the results of such degenerative changes. Infarction, or stoppage of the blood vessels of the myocardium means a seriously weakened heart muscle. Treatment is therefore directed toward preventing rupture and acute myocardial failure. When arteriosclerosis of the heart is due to vascular lesion, treatment consists primarily of increasing the flow of blood through the coronary arteries rather than stimulation of the heart muscle.

History.—Coronary thrombosis (cardiac infarction) was commented upon by scientists of the eighteenth and nineteenth centuries. It was not, however, until the twentieth century that complete diagnosis was made and this condition differentiated from angina pectoris and other heart ailments. Up to this time, myocardial infarction was recognized as a cause of death, but only recently was it found that a diagnosis before death was possible and that all cases are not fatal. Not only are they not fatal but the chances of recovery and return to work are fair. Recent studies on 415 patients revealed that more than half returned to work on full- or part-time. Half that group resumed work within three months after discharge, three-fourths within six months, and nine-tenths within one year.

Today heart afflictions are said to affect two million Americans. The Metropolitan Life Insurance Company figures show an almost perpendicular rise in coronary disease. In 1930, for example, the incidence was 5.6 per 100,000; by 1935 the figure had increased more than 300 per cent. Men are predominantly affected, though women are by no means immune. Commonest age is around 55, but coronary thrombosis may also be encountered in younger persons—in some cases even in the 20-year group. The disease seems to be more common among professional men and those in business organizations. The most common factor is heredity as family history shows a susceptibility to vascular diseases in many instances. Diseases such as diabetes, syphilis, hyperthyroidism and sometimes gout, Buerger's disease, and polycythemia may also be causes.

Hypertension.—The majority of victims are found to have high-blood



Ted Leigh, M.D.

Treatment may include morphine to ease pain and oxygen to relieve air-hunger.

pressure, but extensive studies show that it is not a necessary prerequisite to coronary disease. Many cases have been reported where coronary disease was present in non-hypertensive patients. Many other factors may play their part in causing hypertension or coronary disease and the two are not necessarily found together.

Clinical manifestations.—Most common symptom is an agonizing, vise-like, and constricting pain. While some cases are known in which little or no pain is experienced, it is usually present and substernal or precordial in location. It may radiate to the left shoulder and arm and sometimes to the neck, scalp, jaw, or left scapula. At times there may be only a feeling of numbness or tingling sensation in the finger or arm joints. Not infrequently there is a referred abdominal pain. Pain occurs frequently while the patient is resting or even sleep.

Relief in complete occlusion is not experienced by the use of nitrites as in the case of angina pectoris. Pain may also occur after heavy eating or following severe physical exertion. It may continue for several hours, days, or even weeks. An acute attack is usually preceded by several days of substernal pain and discomfort. Patients may give a history of long suffering from a vague feeling of indigestion after eating. In the acute stage the nature of the pain is such that the patient is conscious of its serious nature and a look of anxiety and fear is often present. The patient displays an ashen gray color and at times is frankly cyanotic. About 50 per cent are in shock.

Most important is an alteration in the circulatory dynamics. Blood pressure is elevated during the early hours of attack in most cases, but subsequently declines considerably below the usual value of the patient. This rise and fall is an important diagnostic sign in differentiating coronary thrombosis from other conditions which appear like it in many ways. When the blood pressure falls to an extremely low point, circulatory collapse is evidenced by a

cold and clammy skin, ashen cyanotic color, rapid, feeble and thready pulse. The patient may be apathetic or even unconscious. Mortality is greater in the latter case. While this resembles surgical shock, there is also some evidence of congestion in either the systemic veins or in the pulmonary vessels. Enlargement of the liver and edema may be present. More common is an engorgement of the pulmonary vessels because as the left ventricle is affected the lungs become engorged. Dyspnea, râles in the base of the lungs, and cough may also be noted.

Respiratory rate may be rapid. Other types of cardiac irregularity (such as auricular flutter, partial or complete heart block, multiple extrasystoles, etc.) may be present during the course of the disease. Tachycardia usually appears but may be absent in cases of posterior infarction. If the area of infarction is centered in the anterior descending branch area, paroxysms of auricular fibrillation (irregular and rapid contractions) may occur. These complications usually disappear without medication; ventricular fibrillation often appears later, however, and is usually fatal.

Fever, although mild, may exist two to four hours after onset of the pain. High fever may mean a larger infarct. Leucocytosis may be slight or, if the count is high, may show a severe myocardium damage. Pericardial friction rub may also be present. An increase in sedimentation rate is also noted in usually from six to forty-eight hours. This is of value in showing progress of the disease although other conditions may be present that increase the speed of sedimentation. Rectal temperatures are preferable as false oral temperatures are noted due to mouth breathing in an effort to relieve air-hunger.

Electrocardiograms are valuable in locating the infarcts and in many cases are routine procedure.

Treatment.—Rest, rest, and more rest is imperative. In the acute stage, bed and complete quiet is ordered. The length of time in bed is determined by the severity of the case, but from four to six weeks is usually advocated. It is well agreed that repair does not set in for three to six weeks. Physical findings and electrocardiogram alterations will rule this time to some extent. After the patient leaves his bed, physical activities should be regulated and never continued if there is a shortness of breath or pain. Each patient must be taught to regulate his living habits according to individual cardiac disability. It must always be remembered that coronary thrombosis represents the end stage of arteriosclerosis of the coronary vessels and occlusion of other vessels may, and often does, occur later.

Morphine is usually given at the early stage of treatment. [*Cont. on page* 42]

HOW TO EQUIP A *First Aid* KIT

BY MARY ANNE WOOD, R.N.

• Today you may run head-on into an emergency! Two cars crash on your way to work . . . a picnicker has a bad fall on your day-off hike . . . there's a nosebleed, burn, or fracture at the country house where you're on a case. As a registered nurse you'll be a help in any of these crises. As an R.N. with an emergency kit you can really give first-aid!

Emergency kits are among my pet "musts." I think every nurse should be given one at graduation as part of her professional equipment. I keep three kits going all the time—one at home, one at my office, one in my car. They've all been used until they are battered, but they have helped me out of many a bad hole.

To set up your own first-aid kit, one suited to your special needs and your own job, is simple and inexpensive—and lots of fun. You can buy a commercial kit and add what you need. Or, you can start from scratch and outfit yourself completely.

Commercial kits range from the small five-and-ten-cent variety to the elaborately equipped cases for factory use. Retail stores report that the most popular ready-made models cost between $1.50 and $5.00 and are compact metal boxes with small supplies of sterile goods and the usual first-aid necessities. In a case in the lower price range you might expect to find sterile gauze dressings (rolls and flats), cotton, ampoules of iodine and mercurochrome, aromatic spirits of ammonia, a burn ointment, applicators, adhesive, ready-made bandages, and perhaps a pair of scissors.

To this you might want to add a few items which I have found indispensable: aspirin, a bottle of mild laxative tablets, an envelope of boric-acid crystals, safety pins, matches, and drinking cups.

You are now suitably equipped to deal with such routine emergencies as the average home or auto trip presents. But if you travel a great deal, as I do, or find yourself at times far from doctors and supplies, you will want a more complete kit—and you'll want to outfit it yourself to include your favorite items.

You won't need an abundance of any one supply, but you will need a great many different things. A variety of materials will keep you prepared for any emergency whereas an over-supply of gauze or disinfectant will only make your kit heavy and bulky.

The first step in organizing your kit is not the outside, but the inside. If you first list all the things you are going to need you can determine what size box to buy. Here is my own list

for my traveling first-aid kit. It is especially planned for visits to isolated areas:

Sterile cotton fluffs
Sterile applicators
1 and 2-inch gauze bandage rolls
2 and 3-inch gauze bandage rolls
6 sterile 2 inch flats
6 one-inch ready-made waterproof bandages
Adhesive, 1½ inch and ½ inch
Soap, matches, wash-cloth
Scissors, forceps, tongue-depressors
Tourniquet
Sanitary pads, safety pins
Tincture of green soap
Alcohol, 95 per cent
Gentian violet, 2 per cent
Mercurochrome, 2 per cent
Aromatic spirits of ammonia
Boric-acid crystals
Bicarbonate of soda
Burn ointment
Collodion
Benzine
Aspirin, gr. V.
Sterile hypo syringe and needles
Paper drinking cups
Ampoules and files

Believe it or not, you *can* pack this imposing array of equipment comfortably into a kit approximately 6 x 10 x 3 inches. There is even some room to spare if you want to add a few items I haven't included. Some nurses may like to carry temporary splints (there have been times when I needed them!), or a sterno stove for sterilizing. The individually wrapped sanitary pads offer a sterile absorbent pressure pad for deep lacerations, as well as meeting those "day early" emergencies which accidents and excitement seem to precipitate.

A foot of soft rubber tubing makes an excellent tourniquet. For tissue forceps you can use eyebrow tweezers. You will find that with tongue-depressors and safety pins you can improvise many useful items.

Solutions and medications should fit your own needs. Tincture of green soap and alcohol are indispensable for cleansing and sterilizing. I like mercurochrome as an antiseptic, supplemented by gentian violet. Benzine is an all-purpose solvent, and collodion protects hard-to-get-at wounds or acts as an adhesive. A single analgesic ointment will treat burns, poison ivy, or abrasions. Aromatic spirits can be used as a stimulant or to relieve nausea. In extremely isolated communities you may need to carry ampoules. Novocaine, amyl nitrite, antispasmodics, stimulants, and opiates may be carried on the advice of a doctor, but the responsibility for deciding when these are indicated lies out of the scope of most of us.

The box for your kit should be durable, dustproof, and waterproof. Try a rectangular metal candy box, shaving kit, or metal [*Continued on page* 40]

EMERGENCY FIRST-AID REPORT

Date ..... **Hour** .....
Name of Injured ..... **Age** .....
Address .....
Location of accident .....
Type & cause of accident .....
Driver of car .....
Driver's license? ..... **Auto license No.** .....
Description of injuries .....
.....
Emergency treatment given .....
.....
Disposition of case .....
Doctor ..... **Nurse** .....

CONTEST WINNER

BY ANNE E. CADY, R.N.

Medicine Woman

• The Navajos call me Asan-sue-e, "the woman with the yellow hair." I live in a fourteen-foot trailer house on top of a 9,000 foot mountain near Fort Defiance, Arizona. Here, for three years, I have been visiting nurse to 50,000 Indians.

In the three years during which I have lived and held "clinic" on the reservation, I have heard the Medicine Man sing fewer and fewer incantations. The R.N. "Medicine Woman" is taking his place. Modern knowledge is making headway against tribal superstition. Every month the waiting line at my trailer door gets longer. I am able to send patients sooner to the Government hospital fifteen miles away; they recover more quickly when hospital care is provided at the outset of a serious illness.

Three years ago, I was sent out from the Good Shepherd Mission of the Episcopal Church at Fort Defiance. I drove my Ford and trailer up and over a mammoth mountain, into the valley, and up on top of another mountain. Here I had orders to "dig in," so that the tribes could have a permanent health advisory service and medical aid in emergencies.

Nine-thousand feet nearer to heaven, and winter coming on! Snow and sub-zero weather set in and the trailer, built for summery climes, got colder and colder. Then we had an inspiration. Why not insulate? We built a board shed around the trailer, leaving peep-room out the windows. Between the trailer and the boarding we packed sawdust. Lo! we were snug and comfortable and could carry on our work. My assistant and I have been here ever since.

From that time forward, our trailer clinic has kept office hours day and night for emergencies of every sort. Since there's no doctor or minister for miles around, we perform the emergency functions of both. We hold church services twice a week in the schoolhouse, and burial rites for the dead. It's important to offer these people a

Every Indian mother proudly brings her papoose up to the trailer-house for Miss Cady's inspection.

religion to supplant their dying mythology, just as it's vital to put science in the place of the disappearing medicine man.

When a patient arrives (usually winded) to see me, I can expect almost anything. It may be a worker from the nearby Government sawmill, badly injured by the machinery. It may be an infant with a bad case of impetigo—a disease which runs rampant in the unsanitary homes here. It may be pneumonia at any time of the year. Indians are very susceptible to all respiratory diseases.

Trachoma haunts us. The tribes are full of acute and chronic cases. We have tried everything. Irrigations and ointments usually help to some extent and, lately, cases treated with sulfanilamide have been interesting to observe and have shown excellent results.

In cases of severe illness, I still meet the medicine man. Nowadays, however, the nurse is called at the same time, and asked to give *her* medicines! I have learned not to interfere when the medicine man makes sand pictures on the floor of a Navajo house and the patient is stripped and covered with soot during the singing. I know by this time that after the formalities we will be able to take the patient to the hospital without protest. Considering the Indian's native reluctance, I think we've made great progress.

Modern medicine has won over the Indian partly because of its cures—often so much more dramatic than those of the medicine man. Much of the charm of my treatments, however, lies in—the fine-smelling medications! The Indians love liniment! I can never keep enough of it on hand to satisfy their demands. Next to liniments, they like high-smelling ointments, and porous plasters! It's fortunate for me that they're fond of plasters. It makes pneumonia treatments much more easily accepted!

My medicine chest is quite simple. It contains such usual medications as mercurochrome, ammoniated mercury, ichthyol, Unguentine, zinc ointment, aspirin, epsom salts, and milk of magnesia. A complete first-aid kit is ready for accidents. Dressing materials are scarce and I occasionally have to take up a tribal collection for funds to replenish my supply.

Childbirth here is still in the hands

Snowed in! During bad weather, the trailer is insulated against wind and cold. The nurse's car, however, stands uncovered, has to be able to "take it."

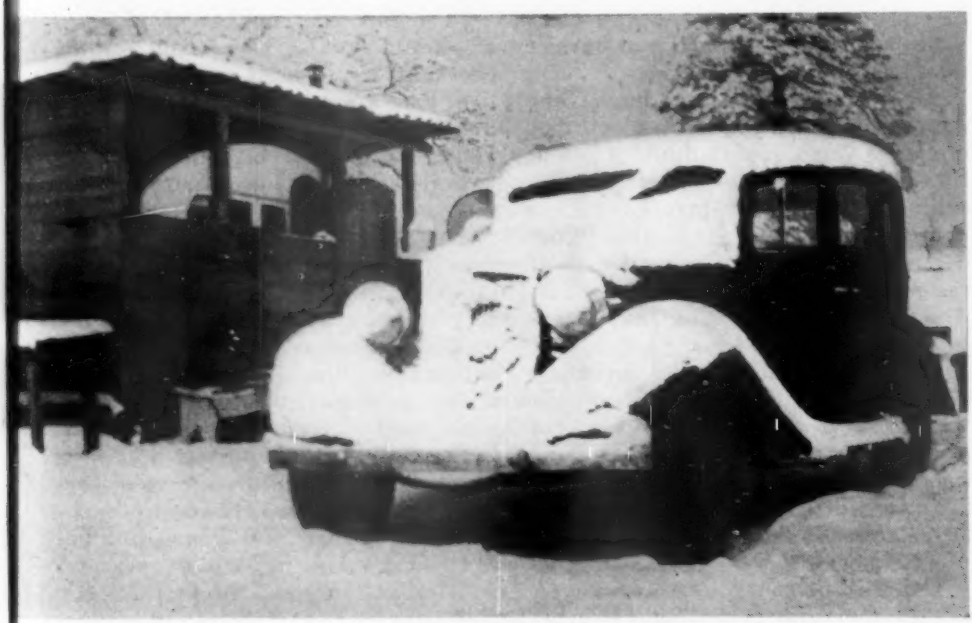
of the Navajo midwife. I'm seldom asked to attend, unless complications ensue. Here, surely, is a big opportunity for some public-health work in the future. At present the *accouchement* is an unsanitary process, to say the least! A woman in labor is never allowed to lie down; she kneels on the floor and pulls on a rope hung from the ceiling. The midwife squeezes the abdomen until the baby is born. The cord is tied with any old string and the placenta, wrapped in a sheepskin, is put in the top of a tree. If it is buried the baby will grow up to be lazy!

The extent of our public health teaching thus far, has been to try and make clear to the Indian the nature of infection. It's difficult for him to understand why he shouldn't follow the old custom of daubing a wound with a mixture of pitch from the piñon tree and seeds. This hardens like cement and comes off about as easily. It causes severe infections, well established before we see them and, of course, makes treatment twice as hard.

That contagious diseases are "catching" is another fact alien to Indian understanding, but beginning to be understood. The white man's diseases—measles, syphilis, and tuberculosis—take heavy toll among the Navajos. Now, however, they are willing to consider hospitalization; cures have convinced them that medical and nursing care make sense.

There's much more to be done here on top of our mountain. There's the Navajo diet, for instance. Indians here live on bread, meat, and coffee, seldom see green vegetables. They are just beginning to be much interested in the fact that what they eat relates to how they feel.

Yes, there's much left to be done. But next year, a new medicine woman will be here to do it. After twenty-five years of public-health work among the Navajos, I've been awarded a vacation. The trailer? It will have to stay behind on top of the mountain. There it is the symbol that a medicine woman still holds sway—an R.N. medicine woman!



"The first person you see when you get off the train is—no it can't be Pat Johnson!"

BY ROXANN

'I KNEW HER WHEN—'

• Reunions—ah, yes, reunions.

The morning the invitation comes, you toss it lightly aside. You've lost contact with most of the members of the class, money is scarce, you can't really spare the time, and you haven't a *thing* to wear.

All day as you dash through your appointed rounds you tell yourself that of course you wouldn't think of going. But it would be nice to see little Pat Johnson again, and Mary Brown, so homely that she was fascinating. Wonder if Nancy is still in nursing, or if she married that dumb footballer . . . And whatever became of fiery Francesca Vitallo?

That night you fish the invitation out again and accept it. Then you splurge on a dress that represents a week of brow-soothing and pillow-smoothing, and a hat so funny that all the girls will know it's expensive, and buy a railroad ticket for the little old Alma Mater town.

The first person you see when you get off the train is—no, it can't be. Why, Pat Johnson never weighed more than a hundred pounds in her life!

"Roxy, Ho-oney. Looking younger than ever!" Yes, it's Pat.

"Pat darling! You haven't changed a *bit*!" You kiss her warily on the cheek, trying to keep veil and hat intact. Pat explains that she is in charge of arrangements, and she will see that you are well taken care of.

You have your choice of staying with Mary, who shares a two-room apartment with a librarian, or with Lily, who has a sure-enough house—five miles out in the suburbs. You vote for Lily and the peace and quiet of the country. Somehow, no one remembers to warn you that Lily has four overactive children . . . Peace and quiet, my eye!

The four coldly appraise you in a manner reminiscent of uniform inspection in probie days. There's a glint in Junior's eye that gives you some clue as to what you're in for.

"Mother," he coos. "Mother, I don't see any."

"Go play with Baby," says Lily, clutching him by the collar and gently steering him toward the door.

"But, Mother, you said she'd probably be all decked out in fine feathers and——"

You and Lily titter foolishly. "My, my, one never knows what children will think up——." For the first time you notice Lily's shabby dress, the worn spots in the rug, and the bicycles and trains wrecked by the young demons. Still, they *are* handsome little brutes; and you feel uncomfortably overdressed.

Finally, Lily bundles you and two of her brood into the family car and you set sail for the meeting place. By this time everybody has arrived—everybody and their husbands, children, cats, and dogs, it seems when you first open the door. Were there only forty in your class? This looks more like the Four Million.

There is Beanpole, who has outgrown her name and developed curves in strategic places. My, what a knockout! And blonde, chubby Babyface, gurgling, and dimpling as of yore, though she's a mite too old for that sort of thing now. And Sarah, with her slip still showing. And Doris, good old Doris, your pet hate—looking more like a horse than ever, and not a very distinguished horse at that.

Everybody is dripping, "I'm so-o-o glad to see you," and you fib back gallantly, fumbling frantically to recall names of girls you haven't seen or thought about since graduation. The married ones correct you coyly or with superior looks on their faces. You examine snapshots of John and the kiddies until your face freezes into a half moon and your jaws ache from saying, "What a *dar*-ling baby!"

Some of your classmates lug up husbands who couldn't escape, and exhibit youngsters in the flesh. The kids glower at you, refuse to shake hands as ordered, look you up and down, and give you a non-passing mark then and there. Not that you mind by now. Everybody, including yourself, has been giving everybody else the once-over, covertly, since the clan gathered.

While weak tea is being thrust into your hands (the coffee gave out long ago) you catch up on history. Marta is in England with an ambulance unit. Fannie cast her lot in with a hillbilly and is sharecropping, or whatever you call it. Yes, Nancy married the footballer, and he's coach at some college out on the Coast. Francesca copped off a surgeon, and they're trying to make a private hospital pay. Every one agrees that if they succeed they'll rate an "Oscar" from the American Academy of Hospital Superintendents.

Helen is assistant director of nurses in a big Chicago hospital. Imagine shy little Helen in an executive job! It's a funny world, isn't it? And Marian finally got her man . . . You know, she said she went into training to get a millionaire. She finally landed a wealthy old Third Stage Thoracoplasty, my dear, and then he lost all his money in the depression. Now she's doing general duty in [*Continued on page* 38]

"Some of your classmates exhibit youngsters in the flesh and husbands who couldn't escape. . ."

IN REVIEW

A QUICK GUIDE TO CURRENT BOOKS OF INTEREST TO NURSES

INTRODUCTION TO MATERIA MEDICA AND PHARMACOLOGY.

Hugh McGuigan, M.D., *Robert McGuigan*, M.D., *and Elsie Krug*, R.N. $3.50. *C. V. Mosby Co.* (*Second edition.*)

● A head nurse, who was recently asked her opinion of nursing education's weakest point, promptly replied, "Arithmetic. Most of us are still shaky on decimals."

To eliminate this defect and to strengthen the morale of graduates who still feel shaky, the authors have included in their study of drugs and solutions, a concise and simple chapter on this all-important subject. This makes their discussion of posology (the science of dosage) much more effective than that of the ordinary textbook. It also builds an excellent foundation for their later analysis of drugs and physiological reactions.

The volume (870 pages) describes the latest drugs, serums, and vaccines, and evaluates vitamins from a chemical point of view. All compilations are made in accordance with the newest U.S. Pharmacopoeia, the National Formulary, and the Curriculum Guide.

SURGICAL NURSING.

E. L. Eliason, M.D., *L. Kraeer Ferguson*, M.D., *and Evelyn M. Farrand*, R.N. $3.00. *J. B. Lippincott Co.* (*Sixth edition.*)

● This workmanlike volume puts its emphasis on nursing techniques and avoids involved explanations of surgical procedure. It instructs on the premise that a nurse, expertly trained in bedside technique, is essential to the success of surgery. "Higher nursing education," the authors say, "is an excellent ideal and should be advocated . . . but not at the expense of real actual care of the patient as a human individual, rather than as a pathologic specimen."

Included in the text is a description of

the newest Wangensteen apparatus, late developments in anesthesia, nursing care in use of the Miller-Abbott tube, and many others. New information has been incorporated on gangrene, peptic ulcer, brain surgery, and care of the colostomy.

One topic noticeably absent, however, is a section on bandaging. Is bandaging and the art of dressings no longer a part of surgical nursing?

The book is capably illustrated and is a companion volume to "Essentials of Medicine," offered by the same publisher.

NIGHT NURSING

Catherine E. Reilly, R.N. $2.00. *F. A. Davis Co.*

● This book was especially prepared to meet a need. In working up a series of lectures on night duty, Miss Reilly was unable to find any book or text to help her. So, she wrote one herself.

The author's long experience in private duty and hospital night supervision shows to good advantage in this practical and sympathetic discussion. She has caught the essential problems of nursing at night —the apprehension of patients, and the special emergencies which confront the R.N.

Only drawback to this volume is the slightly lyric style which seems out of place in a professional text. Also unnecessary, in the opinion of this reviewer, is the poetry interspersed between chapters.

A REVIEW OF NURSING

Helen R. Hansen, R.N. $3.00. *W. B. Saunders Co.* (*Third edition.*)

● The trick in revising "old stand-by's" is to do a thorough job of bringing in new facts without altering the value of the original body of material. Few revisers are as conscientious as Miss Hansen has been in completely combing over the text of a new edition.

All subject outlines in this well-known review of nursing have been revised by field specialists. Nearly one thousand new questions test the reader's knowledge of nursing topics.

Aimed at students, this pick-me-up volume will also be a boon to R.N.'s, young and old, who like to learn as they work.

As

ENCOURAGING

as a FRIENDLY GREETING CARD

SOMEONE remembered . . . Immediately the atmosphere of the sick room is brightened. Yes, greeting cards give patients a mental lift. And so does MUM, the snow-white cream deodorant that neutralizes annoying stale perspiration odors.

Make it a habit to personally "air-condition"* your patients with MUM. A few dabs of MUM to perspiration areas almost instantly dispel odors. MUM does not interfere with normal sweat gland activity . . . will not stain clothing or bed linen. Nurses use non-irritating MUM regularly.

MUM applied to sanitary napkins is an effective deodorant . . . excellent for tired, burning feet and foot odors.

MUM TAKES THE ODOR OUT OF STALE PERSPIRATION

*Personal "air-conditioning": the prevention of stale perspiration body odors which so often pervade the office or sick room.

BRISTOL-MYERS COMPANY
19-D West 50th Street • New York, N. Y.

'I knew her when--'

[*Continued from page* 33]

a T.B. sanitorium in order to be with him. Well, it just goes to show you . . .

After the Small Fry have kicked your shins and played tag around and through you all afternoon, comes the hour to take them home to their milk and cod-liver oil. Old Maid that you are, you hope in some subconscious stratum that Mommy will put the little dears to sleep in a nice bed of chloride of lime.

Part of the next day is spent touring the hospital. They certainly have changed the old place. You wouldn't know it. Things are much softer now than in our time. Now, when *we* were here . . . A ripple of knowing eyebrows and tck-tck's, passes through the crowd.

The present crop of students is practically infantile. And silly! *We* would never have giggled with an intern, as that bobbed little whippersnapper over there is doing. Well, not often anyway.

You pass the ward kitchen and somebody says, "Will you ever forget the night we were caught cooking steaks for the boys?" That breaks down the tension, and from that point on it would warm the cockles of any first-year student's heart to hear the hair-raising tales of hospital pranks.

"I boosted Bess through the window, and she got the key . . ." "We dressed up the classroom skeleton and . . ." "Eve had a bid to the Army-Navy game, so she made her twin take her place for two days. The twin was in normal school and what she didn't know about nursing would fill a book. . ." "And the time Sadie and Vi tried giving each other ether. They almost got sacked for that."

The big event, of course, is the dinner at the hotel that night. The village hairdresser does a land-office business, and everybody comes in with waves like a corrugated iron roof. But the strangeness has completely worn off. There's a friendly camaraderie, and no one seems to notice the odd assortment of costumes. Tailored skirts and shirts with a head-nurse air; flowered chiffons—usually on the over-size gals; little woolen numbers "suitable for any occasion;" and candid formals revealing expanses of too, too solid flesh.

Islands of black and white, or good blue serge, show through the night that the husbands are still there, bless 'em, taking their punishment and liking it. There's Mamie's mousey little man, looking as though he should be on a leash. They say that tall, boney Mamie got the poor feller when he was pracically out from a duodenal ulcer. And there's Florence with her life-of-the-party. He's leading a private songfest and playing practical jokes before you can say "wink." Just a card—in public.

Dinner gets under way. Fruit cocktail, direct from producer to consumer, via tin can. Half a broiled chicken, and what a life the poor thing must have

THE CROWNING GLORY

that is woman's hair . . .

Yet you, nurse, have seen hair that is not so glorious — excess, unwanted hair that causes your patients endless, needless distress.

IMRA **cosmetic depilatory, offers a logical and sincere answer to the age-old question of "Nurse, what can I do . . .?" IMRA offers a new chemical principle in scientific depilation—calcium thioglycolate—and several thousand patch tests on normal skin (pH 4.2 to 7.) have demonstrated its amazingly low allergic response. IMRA does not irritate a normal skin. It produces neat, non-messy, and effective depilation in from six to fifteen minutes without any of the annoying disadvantages of the scraping razor blade . . . possible infection and irritation . . . sharp razored stubble. IMRA IS ODORLESS!**

***IMRA*—Available in several sizes at all fine drug stores.**

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Please send me regular 25¢ trial tube of IMRA at the Special Nurses' Offer price of only 10¢. Coin or stamps enclosed.

Please send me free literature only. (*check here*) ☐

Name.....R. N.

Street.....

City.....

led to be so emaciated. Potatoes mashed —after a fashion—in water. Peas as green as arsenic, and tasting only slightly better. A bedraggled salad. Brick ice cream in three delicious flavors, and two small cookies. Coffee? Brr-r-r! Do they call this coffee? The dietitian at your hospital goes up several points in your estimation.

At last a glass is tapped vigorously with a spoon. Here come the speeches. The superintendent of the training school looks strange in civilian clothes. Pat, the president of the class, gets up and forgets what she was going to say, laughs it off and starts over again, and does a good job. Two more speeches and the dancing begins—not exactly swing, but good honest rhythm. You stick it out to the bitter end, though your metatarsals are sagging. Every one seems genuinely glad they came, and genuinely sorry they're leaving.

But aren't you glad that reunions don't happen every year?

First aid kit

[*Continued from page* 28]

hinged cigar box if you don't want to invest much money. Choose bottles with tightly fitting caps and large, wide-mouthed openings. After you have sterilized your bottles, label them plainly. A coat of thin varnish over the label will keep it clean twice as long.

When you are ready to fill up with supplies, go to your local druggist or doctor and explain your idea. You will find that interested professionals will give you small amounts at infinitesimal prices. I was able to secure the medications and bandages for my kit for around a dollar.

Two other things are important in any emergency—a first-aid manual, and record blanks. One of the better booklets on emergencies may serve you better than your memory, for instance, when it comes to poison antidotes. You might also want to review in a hurry the difference between sunstroke and heat exhaustion . . . Almost every life-insurance company and pharmaceutical house puts out a small, accurate first-aid booklet. Boy Scout and Girl Scout handbooks are excellent. Best, perhaps, in the field is the Red Cross First-Aid Textbook. Any of these would fit into the top of a medium-sized kit, ready for instant consultation.

For your own benefit, as well as in the event of legal complications, you would be wise to keep a record of accidents where you are a witness, and of all cases where you give first-aid treatments of any sort. By law, automobile accidents must be reported to the police. An injured person's compensation may be dependent on your record.

From questionnaires furnished by the Red Cross, insurance companies, and police departments, I have compiled a record card (see page 28) which should cover almost any accident. You

can type the form yourself on any 3 x 5 card and keep it with your manual in the top of your kit:

Equipped to meet the gravest of emergencies, you will probably find as I do that first-aid is equally valuable in minor catastrophes. Last week, for instance, my collodion was used to catch a run in a stocking, to paste a notice on an office window, and to protect the landlady's chillblains. The benzine dissolved some misplaced chewing gum, removed typewriter-ribbon ink from a stenographer's hands, and cleaned a stain on my uniform. The soda bicarbonate and aspirin helped ward off a cold and were popular the day following the annual dinner. A bit of adhesive tape temporarily mended a broken window.

I repeat: a first-aid kit is a *must!*

Coronary thrombosis

[*Continued from page* 26]

in order to control pain and induce sleep. It also lightens the heart effort by slowing the pulse and lowering metabolism. After cessation of pain a sedative, such as phenobarbital, may be effective in promoting relaxation and sleep. Oxygen affords relief when dyspnea and cyanosis are present. Intravenous administration of theophylline ethylenediamine (aminophyllin) in glucose solution may have a beneficial effect on the dyspnea and on the pain.

Some disagreement exists regarding the use of digitalis, but in most cases it is given orally in small amounts after the tenth or fourteenth day. Otherwise there may be some danger of dislodging emboli or causing ventricular rupture. In some cases where cardiac failure follows temporary recovery it is often possible to restore function and promote relaxation and sleep through the use of this drug. When auricular flutter or chronic auricular fibrillation is present with a rapid ventricular rate, or when congestive heart failure has su-

ADVANCES IN CANNING TECHNOLOGY

II. Development of the Tin Container

● Appert, discoverer of canning, did not know the reasons why his procedure for food preservation was successful. He clearly recognized, however, that his containers must be so constructed and sealed as to prevent contact of the food therein with air, after heat processing. Today we know that this is necessary to prevent re-infection of the food with air-borne, spoilage micro-organisms.

As containers, Appert suggested glass containers sealed by corks; the reason given is that glass is the "matter most impenetrable by air" (1). In 1810, one year after Appert's discovery was announced, Peter Durand, an Englishman, patented a procedure very similar to Appert's, which covered the use of a variety of containers, among them "vessels of tin (tin-plated iron)." From that time forward, the use of tin-plated containers rapidly progressed.

Commercial canning began in America about 1819. In 1825, Kensett and Daggett, two pioneers of canning in this country, received an American patent covering the use of tin-plated containers. Shortly thereafter, the name "tin can" was coined from the abbreviation of the formal name, "tin cannisters."

The story of the development of the tin can in America is an absorbing one which has been related in more detail elsewhere (2, 3, 4). By the time of the war between the States, the "hole and cap" type of can had been evolved. About 1890, can-making machinery was introduced to replace the older hand-manufacturing operations whereby a skilled artisan could produce about 6 cans per hour. Modern can-manufacturing lines operate at speeds as high as 350 cans per minute.

The first three decades of the current century witnessed the development of machinery to make the modern type or "sanitary style" can now universally used for fruits, vegetables, and a wide variety of other products. The past ten years have brought vast improvements in the tin plate from which cans are made. Not long ago, almost any type of sheet steel was considered satisfactory. Today plate for cans must comply with rigid physical and chemical specifications established by the Research Laboratory of the can manufacturer.

As far as can be determined, tin containers were first introduced to avoid breakage which was experienced with the glass containers proposed by Appert. The other desirable characters of the tin container for foods were not fully appreciated at first; among these advantages should be mentioned its rapid rate of heat transfer, its low weight in relation to its capacity, and its opacity to light. Nor was the importance which the tin can has attained in our national life fully appreciated until world developments caused America to pause and take inventory. Only then was it generally realized that from its humble start 130 years ago, the tin can has risen to become an indispensable article in our modern civilization.

AMERICAN CAN COMPANY, 230 Park Avenue, New York, N. Y.

REFERENCES

(1) 1811. The Art of Preserving. M. Appert, Black, Parry and Kinsbury, London.

(2) 1937. The Canning Clan. E. C. May, The Macmillan Co., New York.

(3) 1937. Appertizing. A. W. Bitting, The Trade Pressroom, San Francisco.

(4) 1940. The National Geographic Magazine, November, p. 659.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-eighth in a series which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

pervened, it may prove of value. Numerous other types of medication are used in certain complications with varying effect. In many cases the results of degeneration and massive infarction has left little cardiac muscle on which a drug may act.

In order to further spare the patient all physical effort during the first ten days or two weeks, the bowels should be regulated by means that will prevent straining or undue motion. Preparations of agar or petrolatum may be used to promote elimination without chemical action. Cathartics are usually avoided, but a retention enema of olive oil may be of aid.

Diet should be simple and such that it will not cause abdominal distention. Plain, bland diets are advisable and if coarse foods (such as bran and certain vegetables) are used to combat constipation, their effect on the gastrointestinal tract should be studied.

*

Treatment of coronary thrombosis is a typical example of the advances made in medicine. Not many years ago this disease was considered rare. Today it is known as an all too common condition—but one that can be diagnosed in a reasonably accurate manner and treated with fair success.

[*For a bibliography of the procedures discussed in this article, send a stamped addressed envelope.*—THE EDITORS]

• Under King Henry II of England in the 12th Century, each of the four known women nurses in the kingdom had to swear annually in the king's presence that they practised no witchcraft in curing their patients. The king would then license them at so much per year.

• Hundreds of victims of the 1515 witch craze were old women whose common sense in nursing was superior to the bigoted and short-sighted muggling of the recognized doctors. Several physicians, enraged at cures effected by their nurses, accused them of witchcraft before the fanatic Carpzou.

You want to go to camp

[*Continued from page* 15]

interested in the infirmary and its equipment, the medical supervision, and hospital facilities. How does the camp manage its physical examinations, and what is your responsibility there? Some camps ask nurses to take on counselor duty, supervision of the dining room, or some clerical work in addition to their duties as R.N.

Salary is only important in relation to other considerations. You might have only a small salary with excellent working conditions, a half-day off a week, and only nursing responsibilities, with carfare paid, and privilege of using camp equipment. Such a set-up would be a much better bet than a higher salary with long hours and too many responsibilities. No set rule can be made for salaries. They run anywhere from maintenance alone to about $300 a season and maintenance. About $100 a season and maintenance seems an average figure with many good organizational camps paying slightly less.

A first interview is a fine time to get a good line on just what your job may entail. You may not have another chance to ask questions until you actually become a tent-dweller! Ask about camp uniform. You'll probably wear your traditional white, with cap and hospital regalia only when you're having inspection or holding clinic, but your employer may have definite specifications as to suitable camp outfits. Review briefly the nursing responsibilities you are to assume, the amount of group teaching and conference work in addition to regular routines.

Once the job is yours, you have all Spring to anticipate and get ready, to brush up on first-aid, buy Red Cross textbooks on this subject, catch up on the newest camping theories. Excellent material on camps can be had from the American Camping Association, 330

When Supplementary Feedings are Ordered...

Nutritious, vitamin and mineral rich Ovaltine presents many advantages when supplementary feedings are ordered. Highly palatable, yet mechanically and chemically bland, it is readily accepted by the patient, even when many other foods are refused.

It is more easily digested than milk alone, since in its preparation the curd tension of the resultant mixture is greatly reduced. Hence no undue burden is imposed upon the digestive tract.

Three glasses of Ovaltine—the amount usually ordered daily—prepared according to directions, furnish 2578 I. U. vitamin A, 302 I. U. vitamin B_1, 491 Sherman-Bourquin units vitamin G, 327 I. U. vitamin D, 1.05 Gm. calcium, 0.903 Gm. phosphorus, 8.9 mg. highly available iron, and 0.75 mg. copper.

The proteins of this pleasant food drink are of high biologic value, its carbohydrate and well-emulsified fat are readily absorbed, and its diastatic action facilitates digestion of starches.

■

Registered nurses are invited to send for a supply of individual servings of Ovaltine. The Wander Company, 360 North Michigan Avenue, Chicago, Illinois.

NEW IMPROVED *Ovaltine*

2 KINDS—PLAIN AND CHOCOLATE FLAVORED

Ovaltine now comes in 2 forms—plain, and sweet chocolate flavored. Serving for serving, they are virtually identical in nutritional value.

State Street, Ann Arbor, Michigan. Any good public library will have a small section of its shelves devoted to camping fundamentals.

As you wax enthusiastic over fire-building, boating, and overnight hikes, your summer of nursing may begin to look like the vacation of your dreams. But beware the too-rosy outlook. Camp nurses of many years' experience will tell you that there are hectically busy spells, dreary rainy days, and frightening accidents. There are mosquitoes, poison ivy, sunburn, and homesickness, as well as the charms of the country.

But keep these veteran campers talking . . . and they will say with a look in their eyes that camping "gets you." Once you've been a camp nurse, you have the habit. And after New Year's, every year, you start again, checking ads, writing applications, and looking over a well-worn supply of shorts and sweaters . . .

Industry opens up

[*Continued from page* 21]

tively minor role. Prior to 1936, there were only four State health departments which concerned themselves with industrial health. The Federal Government was quietly interested through the Department of Labor. Came Social Security, and close on its heels, preparedness. Latest figures (R.N.—Dec. 1940) show 32 States actively interesting themselves in hygiene for the worker. Federal funds help support this work for Uncle Sam is vitally interested in seeing that illness doesn't stall production.

In Washington, the USPHS, the Department of Labor, the Social Security Board, and the National Defense Council all worry about industrial health. Through State departments, Government research and advice will become very familiar to nurses in defense industries during the next year. R.N.'s in industry must learn to familiarize themselves with Government services, to watch for new facts on toxic products and processes, to investigate Government laboratory services, and to reach out for information on special diseases like cancer, syphilis, and tuberculosis.

These are all "outside" contacts which nurses in fields other than industry seldom have an opportunity to make. Even the industrial patient requires different methods of handling than the average patient in hospitals and homes. Here is not a sick, hospitalized patient, but a well and vigorous worker. Perhaps he is injured, perhaps he is merely reporting for a routine physical exam or a Wassermann.

Industrial nurses report that their contacts with patients are quite different from any other nurse-patient relationship. Friendly informality is the keynote of a successful industrial health program. (In a factory the R.N. may actually call her patient by his first

name!) It's all in the cause of that important item in industrial health—goodwill.

With all these important responsibilities, industrial nursing requires its own special set of standards. Nurses in industry are quick to realize the essential fact that few of the existing techniques apply exactly, that theirs is a field where standards must vary with factory set-ups and medical needs. Industrial health problems have to be solved where they began—in first-aid rooms and health departments. As the field continues to expand, standards will emerge from among these experienced nurses now in industry and from those who will shortly enter it.

Toward this end, industrial nursing is already well organized. The formation of industrial nurse clubs in widespread sections of the country is a fact of importance far above the as-yet small membership numbers. Twenty-five years ago, the New England club was formed, and it today assumes leadership of all groups. Other groups strong in leadership exist in New York, New Jersey, and Pennsylvania. In Milwaukee, Cleveland, Chicago, and Gary-Hammond other clubs are making names for themselves. In Pennsylvania, Massachusetts, Michigan, Georgia, and Minnesota industrial nurses are organized as sections of their SOPHN'S. A Texas group, organized last Fall, will become an official section at the annual State meeting April 15th.

Already, these clubs are making their own rules. The New York organization studied salaries of its members to discover what is an adequate wage for the R.N. in industry. The eastern clubs as a unit have sought the attention and cooperation of employers by inviting them to meetings, getting together over conference tables to solve mutual problems. Decisions about records and medical supervision are dealt with in club sessions to good effect. [*Turn the page*]

REFRESHING COMFORT

Lorate truly takes the "sting" out of vaginal douching. It is not astringent and not irritating, and discriminating women appreciate the absence of tell-tale medicinal odor. Physicians recognize this appeal to daintiness of Lorate, and are satisfied with its effectiveness as a detergent and for deodorizing whenever vaginal irrigation is indicated.

Lorate is a skillful blend of sodium perborate, bicarbonate and chloride, with menthol and aromatics. Indications for its use include routine cleansing after menstruation; as a detergent in leukorrhea, Trichomonas vaginalis and other forms of vaginitis, in cervicitis, douching after childbirth and after gynecological operations, for pessary wearers, and as a deodorant in conditions attended by fetid discharge.

A trial supply will be sent you upon request. Lorate is supplied in 8-ounce containers.

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Knottiest problem of all is the question of minimum standards for industrial nursing posts. The NOPHN in 1939 suggested educational standards for the factory nurse, but industrial nurses themselves claim that not one of their number in ten can meet them. Employers further complicate the situation by declaring the NOPHN recommendations "too far ahead for the present emergency." (This, despite the fact that the NAM "agrees in principle" with the recommendations set down.)

To this argument the NOPHN replies that its standards were not offered arbitrarily, but were designed to serve as a guidepost to better care in the future. The organization believes that nurses now in the field have equipped themselves "the hard way." Executives at headquarters claim that these women have learned on the job many of the things new candidates might acquire "less expensively," as they put it, "both for themselves and those they serve."

The NOPHN agrees that we may have a tremendous emergency arising which will require short cuts. On the other hand, they believe everyone should understand that short cuts may be necessary as a substitute—but not as a desirable and permanent reduction in standards.

In the face of a new industrial tenseness, and an overnight preparedness boom, industrial nurses are finding their profession "new and different" indeed. That they are ready and able to paddle their own canoes in a dizzily changing nurse situation is definitely to the credit of this highly specialized branch of nursing service.

• One of the earliest Florence Nightingales on record was Countess Beatrice von Mahlenstcheinburg. In 1647 she followed her lover, Audrey d'Aurecout, to the battlefield and, shocked by the sufferings and neglect of the common soldiers, organized a staff of nurses and what was possibly Europe's first military hospital.

COLLECTORS' CORNER

Hobbyists! Anything from Acorns to Zebras (toy of course) can be paged in this corner. If you want new items for collection, or will trade with other R.N.'s, *address the* HOBBY EDITOR. *Letters should be short, to permit inclusion of as many as possible each month.*

* * *

TREES: Who'll send me a tree?—a photo of course. I'm particularly interested in unusual, or historical tree pictures. I'll pay for same, or perhaps send something for your collection in exchange. Flo Perkins, 74 Florence Ave., Hempstead, N.Y.

AMERICAN STAMPS. Are there any R.N. readers who would like to exchange cancelled stamps with me? I am especially interested in North and South American issues. Minie M. Sawyer, 296 Pindle Ave., Englewood, N.J.

CARTOONS. I am starting a collection of cartoons about doctors, nurses, and patients. I will gladly pay postage for all cartoons received or for information as to where they might be obtained. Dorothy H. Karl, 27 Jay St., Gloversville, N.Y.

PRECANCELS: United States postage stamps, especially Precancels, are my hobby. These stamps have the name of the town or city between two black lines across the stamp. I'd like one from each State. Min-

HERE IS THE WAY NURSE HELEN COBB AVOIDS THIS NASTY, MESSY JOB

Since Helen first put on her cap
She filled her job with verve and snap.
Her extra care and extra fuss
Insured her patients "service-plus."

But one job Helen really hates
Is scrubbing patients' dental plates.
So Helen used her pretty bean—
Let POLIDENT soak *dentures clean!*

For POLIDENT just can't be beat—
Keeps dentures pure and clean and sweet.
You simply soak, *then* rinse. *That's ample!*
Write in today for your free sample.

WORKS LIKE MAGIC

Soak 10-15 minutes - Rinse - That's All!

Brushing false teeth is dangerous . . . as well as unpleasant. Polident minimizes danger of hand-infection from unclean plates . . . lessens possibility of scratching, dropping or otherwise damaging expensive dentures.

Cleans, Purifies **— WITHOUT BRUSHING**

POLIDENT *dissolves* away all traces of dingy film and discoloration . . . *soaks* out odors . . . leaves plates looking LIKE NEW. It gets into every tiny crevice where brushing can't reach . . . won't harm dentures . . . is used and recommended by leading dentists everywhere.

WRITE FOR YOUR FREE SAMPLE—TODAY. Send name and address to Hudson Products, Inc., Dept. A2, 220 West 19th St., New York, N. Y.

POLIDENT

nie M. Sawyer, 296 Pindle Ave., Englewood, N.J.

HOSPITAL CARDS. I am saving picture postcards of hospitals anywhere, colored or plain. It would be interesting to see how many I would receive from R.N. readers. All will be acknowledged. Jessie Mae Evans, 1004 Tamm St., St. Louis, Mo.

Where to find our advertisers

INTERESTING PRODUCTS

Here is a check-list on new products and services. You may have samples or literature by writing the manufacturers. The service is available only to registered nurses, so be sure to give your registration number.

DEODORANT: Here is a new powder deodorant which comes in a unique container. SNO-MIST comes in a metal can with patented atomizer top which permits you to spray this fine powder where wanted without mess or waste. The powder sprays freely and when rubbed slightly forms a clinging, cream-like film. It is said to be antiseptic, soothing to the skin, harmless to fabrics, and above all a safe protection against odors. Recommended as a special convenience in cases where an effective personal deodorant adds to the patient's comfort. For free sample address The Phillips & Benjamin Co., Dept. RN 2-41, Waterbury, Conn.

COVERMARK: Articles in the general press have called Lydia O'Leary's COVERMARK "the modern miracle." It is no miracle but a scientific preparation created to conceal birthmarks, X-ray burns, leucoderma, varicose veins, dark circles under the eyes, and other discolorations. It's easy to apply and stays on until removed. Recommended by dermatologists, it has been tested and approved for advertising by the American Medical Association. When you write for your free sample specify whether you are blonde or brunette. Lydia O'Leary, Dept. RN 2-41, 551 Fifth Ave., New York, N.Y.

VITAMIN C: Did you know that canned grapefruit juice is the cheapest practical food source of Vitamin C, excepting only cabbage? Research indicates that few vegetables or fruits, other than citrus, can compare with grapefruit—fresh or canned—as a cheap, dependable, year-round source. These and many other time and money-saving facts are contained in a new booklet being offered by the FLORIDA CITRUS COMMISSION. A "must" for public-health nurses, nurses in clinics, and those who work with low-income families. Write Florida Citrus Commission, Dept. RN 2-41, Lakeland, Fla.

FACTS ABOUT NAILS: Nurses' fingernails need special care if they are to be kept strong and healthy. The makers of DURA-GLOSS nail polish now offer an unusual booklet, free to registered nurses, containing twenty-five facts about care of the nails. Supervised by a well-known physician, the booklet is medically correct and informative. Useful to you—and your patients. Write for as many copies as you wish. Lorr Laboratories, Dept. RN 2-41, 200 Godwin Ave., Paterson, N.J.

5-VITAMIN DRINK: Have you had your vitamins today? Nurses particularly need plenty to increase resistance to fatigue and winter ailments. Here is a delicious way of taking all five important vitamins—A, B_1, B_2, C, and D. Two teaspoonfuls of CAL-C-TOSE in a glass of milk twice daily will give you or your patients ample supplies—and provide a splendid metabolic boost when at low ebb. Obtain free samples by writing Dept. RN 2-41, Hoffman-La Roche, Inc., Nutley, N.J.

COUGH AID: What with colds rampant this time of year, a reliable cough remedy is in order. PERTUSSIN (sweetened extract of thyme) relieves throat irritation by increasing the natural secretion of protective fluids in the mucous membrane of the throat. It will help dislodge phlegm and promote helpful expectoration. Many physicians throughout the world have prescribed Pertussin for thirty years. For a generous sample bottle write, Seeck & Kade, Inc., Dept. RN 2-41, 444 Washington St., New York, N.Y.

Positions available

ADMINISTRATOR: Experienced R.N., about 40, with southern experience sought. Duties include supervision of nursing staff, purchasing, and running of 75-bed institution in attractively located city. (Placement bureau charges $2 registration fee.) Box C377.

ANESTHETIST: Hawaii. Opening for thoroughly experienced nurse-anesthetist, in early thirties. Small hospital. (Placement bureau charges $2 registration fee.) Box MB2-1.

ANESTHETIST: Midwest. Nurse-anesthetist for small private hospital, fully approved and maintaining all diagnostic facilities of much larger institution; operations average three to five daily. Excellent location; small town less than 100 miles from Detroit and Ann Arbor, Mich. (Placement bureau charges $2 registration fee.) Box MB2-2.

CHIEF ANESTHETIST: South. Well trained, member of N.A.N.A., for unusually fine opportunity, large southern hospital. Salary, $100; full maintenance. Attractive quarters. (Placement bureau charges $2 registration fee.) Box C379.

DIRECTOR OF NURSES: East. Experienced woman sought for private institution maintained by philanthropy. Approximately 150 beds, all-graduate nurse staff. General service. (Placement bureau charges $2 registration fee.) Box MB2-4.

DIRECTOR OF NURSES: Pacific Northwest. Opening in fairly large hospital for strict disciplinarian with full knowledge of her duties. Must have previously served successfully as director of nurses. Duties will probably include those of assistant administrator. Woman of 45 or 50 preferred; younger woman eligible. (Placement bureau charges $2 registration fee.) Box MB2-5.

DIRECTOR OF NURSES: West. Large teaching hospital; approximately 200 students; particularly attractive connection. Salary, $3,000; maintenance. (Placement bureau charges $2 registration fee.) Box MB2-6.

DIRECTOR, SCHOOL OF NURSING: Candidate must be college graduate with teaching and supervisory experience; pediatric training essential. Interesting appointment in children's hospital. Large central city. Salary, $140; maintenance. Excellent living quarters. (Placement bureau charges $2 registration fee.) Box C382.

GENERAL DUTY: California. Two day and two night general-duty nurses for large general hospital operated by group of physicians. All-graduate staff; eight-hour day, six-day week. (Placement bureau charges $2 registration fee.) Box MB2-7.

GENERAL DUTY: Michigan. Several openings in large, fully approved hospital. Eight-hour day, six-day week. Salary, $90; room, laundry; increasing to $95 at end of year and $105 at end of second year. Meals obtainable at low cost in hospital cafeteria. (Placement bureau charges $2 registration fee.) Box MB2-8.

GENERAL DUTY: Michigan. Opening in hospital fairly close to Detroit. Eight-hour schedule. Salary, $100; meals, live out. (Placement bureau charges $2 registration fee.) Box C385.

***GENERAL DUTY:** New York. Openings for general floor duty; registered in State of New York. Salary, $60; maintenance. Box BCH2-1.

GENERAL DUTY: South. Openings for several in large teaching hospital. Prefer nurses with postgraduate training who can be promoted to head nursing positions involving executive duties and teaching. (Placement bureau charges $2 registration fee.) Box MB2-9.

INSTRUCTOR, CLINICAL: Chicago area. Duties will include clinical instruction in medical and surgical nursing. (Placement bureau charges $2 registration fee.) Box MB2-10.

INSTRUCTOR, NURSING ARTS: East. Candidate with degree preferred, though not essential. Unusually attractive appointment in large eastern hospital offering excellent professional contacts. Salary, $125; full maintenance. (Placement bureau charges $2 registration fee.) Box C389.

INSTRUCTOR, NURSING ARTS: Midwest. Opening in 600-bed hospital. Excellent school. May report any time up to September 15th. (Placement bureau charges $2 registration fee.) Box MB2-11.

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